Chapter 12: Forms

Summary

Following are examples of some of the forms used frequently by DRS. Some of the forms include detailed instructions and other important information, so be sure to check for additional pages. You can download these forms from http://www.wa.gov/DRS/forms/index.htm if you do not have one and need one for immediate use. You may also call us at 1-800-547-6657 and we will mail you a form.

A Partial List of Forms Available in the Forms Archive on the Web Site

The Forms Archive is designed to provide easy access to many of our more commonly used forms. All forms are in PDF format. We have provided a link to download Adobe Acrobat, so you can access the form files. You can view, print or complete the forms on line. The forms must be printed and signed at your site. Unless otherwise indicated, mail the signed original to the address indicated below.

- Authorization for Direct Deposit—*use this form to have your retirement benefit deposited directly into your personal bank account.*
- Beneficiary Designation—*use this form to document beneficiary information in case of death prior to retirement*
- Beneficiary Designation—**for DCP only**—*use this form to document beneficiary information in case of death prior to retirement*
- Beneficiary Designation—***for LEOFF and WSPRS members only***—*use this form designate or change your beneficiary(s) eligible to apply for benefits under Chapter 226, Laws of 1996 only.*
- Beneficiary Designation—***for LEOFF and WSPRS retirees only***—*use this form designate or change your beneficiary(s) eligible to apply for benefits under Chapter 226, Laws of 1996 only.*
- Credit Redistribution—*use this form to redistribute previous retirement system payments.*

- DCP Payment Advice— *use this form to report payments for* ***DCP only.***
- Enrollment Form—*use this form for initial enrollment in a DRS-administered retirement system*
- Final Compensation Report—*Use this form to provide information DRS needs to calculate the benefits for a retiring member of PERS Plan 1. A political subdivision also uses this form for a sick leave cashout at retirement.*
- Maximum Deferral Worksheet-DCP—*use this worksheet to determine your deferral limit.*
- Participation Agreement—*complete this form to enroll in the DCP*.
- Payment Advice—*use this form to report Plan 1 and Plan 2 payments to DRS.*
- Plan 3 Change of Investment Program—*TRS Plan 3 members use this form to select a new investment program for future contributions; this form should be turned in to the employer.*
- Plan 3 Member Information—*Use this form, in addition to the Enrollment Form, during initial enrollment in TRS Plan 3.*
- Plan 3 Payment Advice—*use this form to report payments for* ***Plan 3 only.***
- Position Eligibility Worksheet—*use this form as an aid in determining position eligibility*.
- Prelist Supplement Form—*Insert this form into the prelist where you need extra pages.*
- Proof of Earnable Compensation—*use for TRS only to finalize the member's account for retirement.*
- Retiree Returning to Work Report—*use this form to report the retirement system in which the retiree is working.*
- Retirement Status (required by RCW 41.50.139)—*reports if member has been a member or retired from a Washington State retirement system.*
- TRS Plan 1 Retiree Returning to Work Report—*use this form to report any TRS Plan 1 retiree who is working for you.*

Forms not Available on the Web Site

- Transmittal Correction Form: *Use this form to correct reporting errors from previous transmittals.*
- Plan 3 Transmittal Correction Form: *Use this form to correct reporting errors from previous transmittals **for Plan 3 only**.*
- Verification of Employment form*: This form is generated by DRS to verify an employee's salary and hours for a specified period.*

Mailing Completed Forms

Mail all completed forms (unless otherwise noted) to the address shown below:

DEPARTMENT OF RETIREMENT SYSTEMS
PO BOX 48380
OLYMPIA WA 98504-8380

Questions Regarding Forms?

If you have questions about the form, please contact the DRS Central Reception Unit at 1-800-547-6657, who will direct your call to the appropriate person, or you may contact ESS.

Need Additional Forms?

For bulk quantities of forms, please call the DRS Mailroom at (360) 664-7066 or on the toll free number, 1-800-547-6657. You may also request forms on E-mail at **drsforms@drs.wa.gov.**

The examples of the forms are listed alphabetically on the following pages:

State of Washington

Department of Retirement Systems (DRS)

AUTHORIZATION FOR DIRECT DEPOSIT

PO Box 48380
Olympia, WA 98504-8380
Telephone
Local: (360) 664-7000
Long Distance: (800) 547-6657

Direct deposit is available to retirees of all DRS-administered retirement systems. Direct deposit allows your payments to be sent directly to your financial institution for deposit in your account.

SECTION A: TO BE COMPLETED BY RETIREE – PLEASE PRINT (See other side for instructions.)

1. Name of payee (Payee defined on back of form)

2. Payee Social Security number:____________________

I, ____, hereby authorize and request

- the Department of Retirement Systems (DRS) to transfer the full amount of my monthly retirement benefit, after authorized deductions, to the designated financial institution for deposit.
- the designated financial institution to provide information to DRS regarding address changes and account information to ensure proper and timely processing of deposit transactions.
- the designated financial institution to refund to the Department of Retirement Systems any overpayments to my account made subsequent to my death or payments made in error.

3. Mailing address of payee (number, street, city, state and zip code)	4. Home telephone ( )
5. Name of retiree (if different from payee)	6. Retiree Social Security number

7. Name of the system from which you receive benefits: (check one)

❑ Public Employees' ❑ Teachers' ❑ State Patrol ❑ Law Enforcement Officers' and Fire Fighters'
❑ Judicial

8. Signature of payee (See Instructions on back)	Date signed

SECTION B: RETIREE'S REMITTANCE ADVICE STATEMENT

When the first payment has been deposited, you will automatically receive a remittance statement at the address provided in Section A, Item 3. Thereafter, if you do not choose otherwise, you will receive a remittance statement when a change is made to your account and at the end of each calendar year. Check one only:

❑ I would prefer to receive a statement when a change is made to my account and at the end of the year.
❑ I would prefer to receive a statement each time I receive a benefit payment.
❑ I would prefer to never receive a statement.

SECTION C: FINANCIAL INSTITUTION TO COMPLETE BELOW THIS LINE

We hereby agree to receive and deposit sums for the payee named herein, in accordance with conditions established by the Washington State Department of Retirement Systems. We further agree to refund to the Department of Retirement Systems any payments received, in accordance to this agreement, which were paid in error or to which the payee was not entitled by reason of errors or his/her death prior to the due dates of such payments.

Name of financial institution	Transit/Routing No. _ _ _ _ – _ _ _ _ – _	
Payment mailing address	Account Type ❑Checking ❑Savings	Number of account to be credited ____________

City	State	Zip Code	Telephone ( )

Authorized signature of financial institution officer		Date
Signature	Title	

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State of Washington

Department of Retirement Systems

BENEFICIARY DESIGNATION

Department of Retirement Systems
PO Box 48380
Olympia, WA 98504-8380
Toll Free: 1-800-547-6657
Local: 360-664-7000
TDD: 360-586-5450

Return completed form to DRS

Important: Before completing this form, carefully read the instructions on page 2. If you are a survivor of a retiree, please list the retiree's name and Social Security Number.

Name of retiree (if different from payee)	Retiree's Social Security Number

Section One: Identification -- Please type or print in dark ink and return completed original form to DRS

Last name	First name	Middle name

Retirement System – check one only

- ☐ Public Employees
- ☐ Teachers
- ☐ Law Enforcement Officers & Fire Fighters
- ☐ School Employees (non-teachers)
- ☐ Judicial
- ☐ State Patrol

Telephone Number (Daytime)	Social Security Number
Telephone Number (Evening)	Are you retired? ☐ Yes ☐ No

Section Two: Beneficiary Designation – You must designate at least one primary beneficary.

Full name of persons or estate (trusts below)	Designation	Relationship	Date of Birth	Address
 Social Security #:	Primary ☐ Contingent ☐ **Must Check one**			Street City State Zip
 Social Security #:	Primary ☐ Contingent ☐ **Must Check one**			Street City State Zip
 Social Security #:	Primary ☐ Contingent ☐ **Must Check one**			Street City State Zip
 Social Security #:	Primary ☐ Contingent ☐ **Must Check one**			Street City State Zip

Trusts or organizations (attach documentation)	Designation	Trustee or Administrator	Address
Name:	Primary ☐ Contingent ☐ **Must Check one**		Street City State Zip

Section Three: Certification -- Complete in full

I, ______________________________(print name), hereby direct that any monies standing to my credit, unless otherwise specified or required by law, will be paid in equal shares to any primary beneficiaries named above who survive me, but if none survive, such monies will be paid in equal shares to any contingent beneficiaries named above who survive me. I hereby certify that I have read and understand the instructions to this form and that all of the information I have entered on this form is true and complete. Submission of this form revokes any prior designations that I have made.

Signature of Member ______________________ Date __________

Address ______________________

City __________ State __________ Zip Code __________

Section Four: Witness – To be completed by a person, other than a beneficiary, who witnesses the member's signature

I, ______________________________, am witness that the above named member completed and signed this document.
Witness name (**cannot be a named beneficiary**) - please print in dark ink

Signature of Witness (**cannot be a named beneficiary**) ______________________ Date __________

Address ______________________

City __________ State __________ Zip Code __________

Note to Retirees: This form **cannot** be used to designate a new beneficiary to receive a monthly survivor option (retirement benefit payment options 2, 3, and 4). Beneficiary(ies) who receive survivor options are named on the retirement application form.

Instructions: Use this form to designate or change your beneficiary(ies) with the retirement system you indicated in Section One. The designated beneficiary(ies) will receive any monies in your account at the time of your death. If you have money in more than one retirement system, you must complete a separate form for each system.

Your designated primary and contingent beneficiary or beneficiaries may be a person, persons, your estate, a trust, or an organization. If a trust is named, the legal documentation must be submitted with this form. Primary beneficiaries will receive any monies in your account when you die. If no primary beneficiary is alive at the time of your death, the contingent beneficiary(ies) will receive the money in your account.

To make your designation:

1. Complete Section One.

2. Complete Section Two and check the appropriate box to indicate whether you wish to make that person or entity a primary or contingent beneficiary.

   When naming a person, always show given names. For example:
   MARY K. DOE (not Mrs. Robert Doe)

   You may designate more than one primary beneficiary. If you do, the funds will be divided equally among all named primary beneficiaries unless otherwise specified or required by law.

   After naming your primary beneficiary(ies), you may name one or more contingent beneficiaries. If the primary beneficiaries are no longer living, the funds will be divided equally among all contingent beneficiaries unless otherwise specified or required by law.

3. Complete and sign Section Three.

4. To protect members from fraudulent claims, it is required that another person witness the member's signature on this document and complete and sign Section Four. A beneficiary cannot sign as a witness.

   Sign and date the form. If the signature can only be made by mark, it must be witnessed by two persons who sign the form. The two witnesses must sign in the witness section and initial in Section Three if marked with an "X."

5. The form must be returned to DRS, PO Box 48380, Olympia WA 98504-8380.

Important: Your beneficiary designation may be invalidated by subsequent marriage, divorce or reestablishment of membership following withdrawal or retirement. Make a copy of your beneficiary designation and review it periodically to ensure that it is still valid.

26 U.S.C. Sections 6047(D), 6041(A), and 6109(A)(3) authorize DRS to solicit your Social Security Number.

- DRS uses your Social Security Number to ensure that any amounts disbursed under your account are properly reported to the Internal Revenue Service and as a reference number for tracking all data with regard to your retirement account.
- Routinely, DRS uses the Social Security Number as the identifying number for the member file.
- If you do not provide your Social Security Number, DRS cannot guarantee that the information you are providing on this form will be properly matched with your member records. This is a particular risk if your name is a fairly common one. Failure to provide your Social Security number may also result in misreporting to the Internal Revenue Service any disbursements you receive, which may result in adverse tax consequences for you.
- Because this form affects how DRS reports your disbursements to the IRS, the disclosure of your Social Security Number to DRS is mandatory.
- DRS will not disclose your Social Security Number to any party unless required by law.

BENEFICIARY DESIGNATION

DCP DEFERRED COMPENSATION PROGRAM

Mail To:
PO Box 40931
Olympia, Washington 98504-0931
Toll Free: 1-888-327-5596
TDD: 1-877-847-6041

STATE OF WASHINGTON
DEPARTMENT OF RETIREMENT SYSTEMS

IMPORTANT: Before completing this form, please read the instructions on the back.

Social Security Number	Employer Name		
Employee Name (Last, First, Middle Initial)		Day Phone ( )	
Street Address		Evening Phone ( )	
City	State	Zip + 4	Birthdate MM DD YYYY
Gender ☐ M ☐ F			

Beneficiary Designation

I understand if I select more than one Primary Beneficiary or more than one Contingent Beneficiary, the total percentage(s) (whole numbers only) for each category must add up to 100%. I wish to designate the following beneficiary(ies) in accordance with the provisions of the Plan:

Primary ☒	Social Security Number	Name: Last, First, MI	Relationship	Date of Birth	Percentage %
	Address: Number	Street	City	State	Zip
Check One: ☐ Primary ☐ Contingent	Social Security Number	Name: Last, First, MI	Relationship	Date of Birth	Percentage %
	Address: Number	Street	City	State	Zip
Check One: ☐ Primary ☐ Contingent	Social Security Number	Name: Last, First, MI	Relationship	Date of Birth	Percentage %
	Address: Number	Street	City	State	Zip
Check One: ☐ Primary ☐ Contingent	Social Security Number	Name: Last, First, MI	Relationship	Date of Birth	Percentage %
	Address: Number	Street	City	State	Zip

I hereby direct any accumulated deferrals in my Deferred Compensation Account to be paid, in the percentages indicated above, to any primary beneficiaries who survive me. If none survive, such monies will be paid, in the percentages indicated, to any contingent beneficiaries who survive me. Completion of this form revokes any prior designations I have made.

X ______________________________

Participant Signature   Date

DRS D 117 (6/00)

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Department of Retirement Systems

BENEFICIARY DESIGNATION for LEOFF and WSPRS Retirees

Toll-free: 1-800-547-6657
Olympia area: (360) 664-7000

Important: Before completing this form, carefully read the instructions on the back.

SECTION ONE: IDENTIFICATION — Please print and complete in full

Last name	First name	Middle name

Retirement System—check one only		Social Security Number
☐ Washington State Patrol	☐ Law Enforcement Officers and Fire Fighters	
Telephone Number (Work or Daytime) ( )	Telephone Number (Home) ( )	

SECTION TWO: BENEFICIARY DESIGNATION—See back of form for instructions

Full name of persons or estate	Designation	Relationship	Date of Birth	Address	
	Primary ☐ Contingent ☐			Street	Mo Day Year
Social Security #:	Check one			City State Zip	
Full name of persons or estate	**Designation**	**Relationship**	**Date of Birth**	**Address**	
	Primary ☐ Contingent ☐			Street	Mo Day Year
Social Security #:	Check one			City State Zip	
Full name of persons or estate	**Designation**	**Relationship**	**Date of Birth**	**Address**	
	Primary ☐ Contingent ☐			Street	Mo Day Year
Social Security #:	Check one			City State Zip	
Full name of persons or estate	**Designation**	**Relationship**	**Date of Birth**	**Address**	
	Primary ☐ Contingent ☐			Street	Mo Day Year
Social Security #:	Check one			City State Zip	
Trust or organizations	**Designation**	**Trustee or Administrator**		**Address**	
Name:	Primary ☐ Contingent ☐ Check one			Street	
				City State Zip	

SECTION THREE: CERTIFICATION—Complete in full

I, ______________________________ (print name), hereby direct that the $150,000 death benefit be paid in equal shares to any primary beneficiaries named above who survive me, but if none survive, such monies will be paid in equal shares to any contingent beneficiaries named above who survive me. I hereby certify that I have read and understand the instructions to this form and all of the information I have entered on this form is true and complete. Submission of this form revokes any prior designations I have made.

Signature of Member		Date
Address		
City	State	Zip Code

SECTION FOUR: WITNESS—To be completed by a person, other than a beneficiary, who witnesses the member's signature

I, ______________________________, am witness that the above named member completed and signed this document.
(Witness's name – please print

Signature of Witness		Date
Address		
City	State	Zip Code

Note to Members and Retirees: This form cannot be used to designate a beneficiary to receive a monthly survivor benefit or a refund of retirement contributions from the Department of Retirement Systems.

Instructions: Use this form to designate or change your beneficiary(s) eligible to apply for benefits under Chapter 226, Laws of 1996. This law provides a $150,000 benefit if your death occurs as a result of injuries sustained in the course of employment as a law enforcement officer or firefighter. Eligibility to receive the benefits will be determined by the Department of Labor and Industries.

Your designated primary and contingent beneficiary or beneficiaries may be a person, persons, your estate, a trust or an organization. Primary beneficiaries will receive any monies payable under this law. If no primary beneficiary is alive at the time of your death, the contingent beneficiary(s) will receive the money. If there is no designated beneficiary still living at the time of your death, the death benefit will be paid to your surviving spouse. If there is no surviving spouse, the benefit will be paid to your legal representative.

To make your designation:

1. Complete Section One.

2. In Section Two, type or print in ink the requested information and check the appropriate box to indicate whether you wish to make that person or entity a primary or contingent beneficiary.

   When naming a person, always show given names. For example:
   MARY K. DOE (not Mrs. Robert Doe).

   You may designate more than one primary beneficiary. If you do, the benefit will be divided equally among all named primary beneficiaries.

   After naming your primary beneficiary(s), you may name one or more contingent beneficiaries. If the primary beneficiaries are no longer living, the benefit will be divided equally among all contingent beneficiaries.

3. Complete and sign Section Three.

4. To protect members from fraudulent claims, it is required that another person witness the member's signature on this document and complete and sign Section Four. The witness must be someone other than a designated beneficiary.

4. The form must be returned to DRS, PO Box 48380, Olympia, WA 98504-8380.

Important: Make a copy of your beneficiary designation and review it periodically to ensure that it is still valid.

This form requests that you provide your Social Security number. 5 U.S.C. Section 552(A) requires that the Department make the following disclosure when requesting that information:

- 26 U.S.C. Sections 6047(D), 6041(A)(3) authorizes DRS to solicit your Social Security number.
- DRS uses your Social Security number to ensure that any amounts disbursed under your account are properly reported to the Internal Revenue Service and as a reference number for tracking all data with regard to your retirement account.
- Routinely, DRS uses the Social Security number as the identifying number for the member file.
- If you do not provide your Social Security number, DRS cannot guarantee that the information you are providing on this will be properly matched with your member records. This is a particular risk if your name is a fairly common one. Failure to provide your Social Security number may also result in misreporting to the Internal Revenue Service of any disbursements you receive, which may result in adverse tax consequences for you.
- Because DRS uses your Social Security number in order to report disbursements to the IRS as required under federal law, the disclosure of your Social Security number is mandatory.

State of Washington
Department of Retirement Systems

CREDIT REDISTRIBUTION

Employer Name:				Organization No.:		
Retirement System	PERS = P	TRS = T	SERS = E	LEOFF = L	WSP = S	Judicial = J
Reporting Group:						

Prepared by:	Telephone Number:

From			To		
System & Plan	Reporting Period or Invoice Number	Payment Number	System & Plan	Reporting Period or Invoice Number	Amount

Mail this form to:

Department of Retirement Systems
PO Box 9018
Olympia WA 98507-9018

For DRS use only:
Approved by: _______________ (DRS Account Manager)
Date:

DRS MS 139 (R5/00)

Using the Credit Redistribution Form

General Information

Use this form to redistribute previous payments. Do *not* attach a payment. To make a payment, use the appropriate Payment Advice form (DRS MS 136 or DRS MS 137 revised 5/00).

A receivable balance is reflected in the Balance Due column on your Statement of Account Activity. If the balance due is a credit (your payment was **greater than** the invoice amount) it will be reflected with a negative sign to the right of the number, for example, **$10.00-**. You may apply all or part of a credit balance to any debit balance (your payment was **less than** the invoice amount). The applied credit may cover only a part of the amount owed. You may apply other credits to the remaining receivable balance, using separate lines. You may redistribute credits between systems and/or plans.

If you have any questions about completing this form, please call your account manager listed on your statement, or call DRS Employer Support Services at (360) 664-7200, or toll-free at 1-800-547-6657, ext. 47200.

Completing the Form

Employer Name	Enter your organization's name as shown on your Statement of Account Activity.
Organization Number	Enter your Organization Number as shown on your Statement of Account Activity; e.g., 0000.
Reporting Group	Enter your DRS Reporting Group as shown on your Statement of Account Activity; e.g., 5000. If you have entries for more than one Reporting Group, list each Reporting Group individually in a separate box.
From **To**	Use the **FROM** column to document the current location of the credit balance. Use the **TO** column to document where you want DRS to apply the credit.
System & Plan	Enter the first letter of the applicable system; e.g., T for TRS. Enter a 1, 2 or 3 for the applicable plan. (Example—T2.)
Reporting Period or Invoice Number	Enter the 8-digit unique Invoice Number for DRS-generated invoices or the 6-digit month-year invoice number used for the transmittals (051998 for May, 1998) as shown on the statement.
Payment Number	Enter the payment number; e.g., check, warrant, or electronic fund transfer (EFT) number, corresponding to the receivable showing a credit balance on the Statement of Account Activity.
Amount	Enter the amount you are moving expressed as a positive number. Do not use brackets or other symbols.

Mailing the Form

Mail this form to the address shown on the front page of this form.

Note: Use this post office box for payments and payment forms only!

State of Washington
Department of Retirement Systems

Deferred Compensation Program
PAYMENT ADVICE

Employer Name:	
Reporting Group:	

Payment Number	Reporting Period	Version/Expected	Amount

System Total for This Page $

Mail this form *with the payment* to:

Department of Retirement Systems
PO Box 9018
Olympia WA 98507-9018

For DRS use only

DRS Receipt Number:

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State of Washington

Department of Retirement Systems

ENROLLMENT FORM

Department of Retirement Systems
PO Box 48380
Olympia, WA 98504-8380
Toll Free: 1-800-547-6657
Local: 360-664-7000
TDD: 360-586-5450

Return completed form to your employer

INSTRUCTIONS: Complete this form if you have never been a member of this retirement system, or if you are returning to the LEOFF Retirement System. If you are enrolling in Plan 3, you must complete a Plan 3 Member Information form in addition to this form. Members in all plans must complete a Beneficiary Designation form.

Section 1: Personal Data - To Be Completed by Member and Returned to Employer

Social Security Number (See back of form)

Male Female

Gender (Check one)

Last Name

First Name

Middle Name

Maiden Name

Mailing Address

City

State

Zip Code

(+4 Optional)

M M D D Y Y Y Y

Date of Birth

Home Phone Number

Work Phone Number

I hereby certify that all of the information I have entered on this form is true and complete.

Signature of Employee

Date

Section 2: To Be Completed by Employer and Returned to DRS

Reporting Group

M M D D Y Y Y Y

First Date of Employee Eligibility

PERS SERS TRS WSP LEOFF

Retirement System - check one

Plan 1 Plan 2 Plan 3

Plan

Elected Official
Gov-Appointed Official
City, County or PUD Manager or Administrator

Special Empl. Type

Employee Position Title

Print or type employer name and mailing address below:

I hereby certify that all of the information entered on this form is true and complete and that the employee's Social Security Number has been verified.

Print Name

( )

Title of Personnel or Payroll Representative

Phone Number

Signature

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DEPARTMENT OF RETIREMENT SYSTEMS
P.O. BOX 48380 Olympia, Washington 98504-8380

FINAL COMPENSATION REPORT

Member Name: ____________________ **SS#** _____________ **Retirement Date:** ________

Department _________ **Employer:** ____

ANNUAL LEAVE

How many hours of unused annual leave did employee have at time of retirement? _________________ (Line 1)

Hourly rate employee was paid for annual leave cashout: _________________ (Line 2)

Calculate the total dollars employee was paid for annual leave at time of retirement:

To arrive at this figure use the formula to the right inserting the figures from above:

____________ X ____________ =$ ____________
(Line 1) (Line 2)

How many hours of annual leave did employee earn each month? ______________

Did employee cash out annual leave other than at time of retirement? (Check one) Yes No

SICK LEAVE

How many hours of unused sick leave did employee have at time of retirement? _________________

How many hours of unused sick leave did employee cashout at time of retirement? ______________ (Line 3)

What percentage was employee paid for sick leave at time of retirement? ______________________ (Line 4)

Hourly rate employee was paid for sick leave cashout: ___________________________ (Line 5)

Calculate the total dollars employee was paid for sick leave at time of retirement:

To arrive at this figure use the formula to the right inserting the figures from above:

_____________ X ___________ X _________ =$ ___________
(Line 3) (Line 4) (Line 5)

How many hours of sick leave did employee earn each month? _________________

Did employee cash out sick leave other than at time of retirement? (Check one) Yes No

Iff applicable, what contract or personnel agreement was this member employedunder? ____

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MAXIMUM DEFERRAL WORKSHEET

DEFERRED COMPENSATION PROGRAM

STATE OF WASHINGTON
DEPARTMENT OF RETIREMENT SYSTEMS

PO Box 40931
Olympia, Washington 98504-0931
Toll Free: 1-888-327-5596
TDD: 1-877-847-6041

When deferring a specified amount of your salary through the Deferred Compensation Program (DCP), your gross salary will be reduced each month by the amount that you have elected to defer. Your deferral cannot exceed 25% of your taxable compensation, limited to $666.00 monthly ($8,000.00 annually). This worksheet will help you determine your limit.

Instructions

Line 1: Enter your gross monthly salary (If paid hourly, enter your estimated gross monthly salary).
Line 2: Enter your retirement percentage contribution, if tax deferred. If contribution is taxed, enter zero.

Retirement contribution rates effective September 1, 2000:
PERS 1 - 6%
PERS 2/SERS 2 - 2.43% — Example: For 2.43%, enter .0243 on Line 2.
TRS 1 - 6%
TRS 2 - 3.01%
TRS 3/SERS 3 - % rate selected
LEOFF 1 - 6.78%
LEOFF 2 - 5.41%
TIAA/CREF - 5%, 7.5%, or 10% (Community Colleges only 403(a)) (Four year universities, see Line 8).
WSP - 3%

Line 3: Multiply Line 1 by Line 2 and enter in Line 3.
Line 4: Enter your monthly pre-tax insurance premium with Heath Care Authority.
Line 5: Enter your monthly Dependent Care Assistance reduction.
Line 6: Subtract Lines 3 through 5 from Line 1 to calculate your "Adjusted Gross Monthly Salary."
Line 7: Multiply Line 6 times 25% to calculate your "Maximum Monthly Contribution." Line 7 may not exceed $666.00 monthly ($8,000 annually). If you are paid in less than 12 months annually, contact DCP for instructions.

If you contribute to an additional Deferred Compensation 457/403(b)/401(k) plan:
Line 8: Enter your monthly contribution to your 457/403(b)/401(k) plan (Four year universities, TIAA/CREF contributions are 403 (b)).
Line 9: Subtract Line 8 from Line 7 to determine your maximum monthly deferral.

Calculator

	Example	
1. Enter your gross monthly salary	1. $ 2,000.00	$
2. Enter your retirement percentage	2. X .0243	X
3. Multiply Line 1 by Line 2	3. $ — 49.00	$ —
4. Pre-tax Insurance Premium	4. $ — 10.00	$ —
5. Dependent Care Assistance Monthly Reduction	5. $ — 400.00	$ —
6. Subtract Lines 3, 4 and 5 from Line 1 to get your	6. $ 1,541.00	$
adjusted gross monthly salary.	X .25	X .25
7. Your maximum monthly deferral:	7. $ 385.00	$
8. Less other 457/403(b)/401(k) Contributions	8. $ — 100.00	$ —
9. Your adjusted maximum monthly DCP deferral	9. $ 285.00	$

DRS D 119 (6/00)

(Numbers are rounded to the nearest dollar)

PARTICIPATION AGREEMENT

DCP DEFERRED COMPENSATION PROGRAM

STATE OF WASHINGTON
DEPARTMENT OF RETIREMENT SYSTEMS

Mail To:
PO Box 40931
Olympia, Washington 98504-0931
Toll Free: 1-888-327-5596
TDD: 1-877-847-6041

Social Security Number	Employer Name
Employee Name (Last, First, Middle Initial)	Day Phone ( )
Street Address	Evening Phone ( )
City / State / Zip + 4	Birthdate (MM DD YYYY) / Gender ☐ M ☐ F

Deferral Information

Your deferral cannot exceed 25% of your taxable compensation, limited to $666.00 monthly ($8,000.00 annually). Please use the maximum deferral worksheet to determine your limit. For information about special provisions that allow you to exceed $666.00 monthly, contact DCP. Deferrals will begin on the earliest date possible, contingent upon the processing time required by your employer's payroll department and the provisions set forth in Section 457 of the Internal Revenue Code. If you prefer to delay starting your deferrals to a later day, indicated begin date here__________________. I authorize my employer to defer $ _____________ OR _____________% (only state agencies may elect %) from my pay monthly.

Investment Allocations

(Use whole percentages only)

(10) Savings Pool	________%	(40) Fidelity Equity Income	________%
(25) WA State Bond Fund	________%	(50) US Stock Market	________%
(70) WA State Short-Horizon	________%	(60) Fidelity Retirement Growth	________%
(71) WA State Mid-Horizon	________%	(75) Fidelity Growth Company	________%
(72) WA State Long-Horizon	________%	(77) Fidelity Overseas	________%
(30) CSIF Balanced Portfolio	________%	TOTAL must equal	**100%**

Beneficiary Designation

I understand if I select more than one Primary Beneficiary or more than one Contingent Beneficiary, the total percentage(s) (whole numbers only) for each category must add up to 100%. I wish to designate the following beneficiary(ies) in accordance with the provisions of the Plan:

Primary ☒	Social Security Number	Name: Last, First, MI	Relationship	Date of Birth	Percentage %
	Address: Number	Street	City	State	Zip
Check One: ☐ Primary ☐ Contingent	Social Security Number	Name: Last, First, MI	Relationship	Date of Birth	Percentage %
	Address: Number	Street	City	State	Zip
Check One: ☐ Primary ☐ Contingent	Social Security Number	Name: Last, First, MI	Relationship	Date of Birth	Percentage %
	Address: Number	Street	City	State	Zip

Important: Read before signing. I authorize my employer to deduct the amount or percentage set forth above each month and transmit to the Deferred Compensation Program. I further authorize my employer to deduct any deferral changes I request through the Deferred Compensation Program in the future. This agreement will continue until further notification by me, as set forth in the plan. I understand a plan expense will be applied to my account value. I acknowledge I have read and understand all sections of the "Memo of Understanding" on the reverse side of this agreement.

X____

Employee Signature Date

DRS D 112 (6/00) White Copy - DRS Pink Copy - Employer Yellow Copy - Participant

DCP DEFERRED COMPENSATION PROGRAM

MEMO OF UNDERSTANDING

STATE OF WASHINGTON
DEPARTMENT OF RETIREMENT SYSTEMS

Mail To:
PO Box 40931
Olympia, Washington 98504-0931
Toll Free: 1-888-327-5596
TDD: 1-877-847-6041

THIS MEMO HIGHLIGHTS CERTAIN PROVISIONS OF THE DEFERRED COMPENSATION PROGRAM. FOR SPECIFIC DETAILS, YOU SHOULD REFER TO A COPY OF THE PROGRAM SUMMARY AND REGULATIONS.

I understand the following:

1. My gross salary will be reduced each month by the amount that I have elected to defer. That amount cannot exceed 25% of my taxable compensation, limited to $666 monthly or $8000 annually (use the maximum deferral worksheet to determine your limit). It is my responsibility to ensure that my deferrals under this and other plans in which I participate do not exceed the allowable amount specified in IRC § 457; if they do, my employer may disallow deferral of the excess, which also may be taxed currently. However, during the last three years before attaining normal retirement age I may be able to defer a greater portion, subject to IRS limitations. For information about special provisions that allow you to exceed $666 monthly, contact DCP.

2. My deferral cannot begin sooner than the month following Participation Agreement approval (WAC 415-501-410). My accumulated deferrals will be held in trust by the Washington State Investment Board for the exclusive benefit of participants and their beneficiaries until paid to me under the rules of the Plan (WAC 415-501-580). I realize that I may not assign or transfer my rights in the Plan (WAC 415-501-570).

3. I have elected to have my deferred salary invested as indicated on my Participation Agreement.

4. Earnings, if any, will be applied to my accumulated deferrals in accordance with the investment option I select (WAC 415-501-475).

5. I may change or stop the amount I defer and may change my investment(s) by using the Voice Response Unit (VRU), the Internet, customer service representatives or by submitting the proper form, which can be obtained on the Internet or by calling the DCP Information Line.

6. There are only three reasons for withdrawal of my funds: Separation from service (WAC 415-501-485), an approved unforeseeable emergency (WAC 415-501-510), or an approved voluntary in-service withdrawal (WAC 415-501-500).

7. I may elect the date and method of distribution of my accumulated deferrals according to those methods approved by the Department (WAC 415-501-490). In the event of my death, any unpaid benefits will be paid to my designated beneficiaries (WAC 415-501-486).

8. The Department retains administrative control over the plan and the employer retains the right to terminate the plan (WAC 415-501-530 and WAC 415-501-540).

9. Neither my employer, nor the Department, nor its individual members, shall be liable for the performance of investments.

10. **I understand that I will receive a copy of any applicable prospectuses and an enrollment confirmation notice, indicating acceptance into the plan. I acknowledge that I have received a copy and understand the Deferred Compensation Program summary and regulations.**

DRS D 112 (6/00)

State of Washington
Department of Retirement Systems

PAYMENT ADVICE

Employer Name:	
Reporting Group:	

Payment Number	Plan	Reporting Period or Invoice Number	Amount
	1		
	1		
	1		
	1		
	1		
	1		
	1		
	1		
	1		
	1		

Plan 1 Total for This Page $

Payment Number	Plan	Reporting Period or Invoice Number	Amount
	2		
	2		
	2		
	2		
	2		
	2		
	2		
	2		
	2		
	2		

Plan 2 Total for This Page $

System Total for This Page $

Mail this form *with the payment* to:

Department of Retirement Systems
PO Box 9018
Olympia WA 98507-9018

For DRS use only

DRS Receipt Number:

DRS MS 136 (R5/00)

Using the Payment Advice Form

General Information

Use this form to report Plan 1 and Plan 2 payments to DRS. Use a separate form for each Reporting Group number. (Use DRS 73302A, revised 12/98 for Plan 3 payments.)

To redistribute a previous payment, use the Credit Redistribution form.
(DRS 733021, revised 12/98.)

Electronic fund transfers transmitted through HRISD and CIS are not reported on this form.

If you have any questions about completing this form, please call your account manager.

Completing the Form

Employer Name	Enter your organization's name as shown on your Statement of Account Activity.
Reporting Group	Enter your DRS Reporting Group as shown on your Statement of Account Activity; e.g., 5000. If you have payments for more than one Reporting Group, use a separate form for each.
Payment Number	Enter the number of the check, warrant, journal voucher (JV) or other payment document. A single payment document may be used for more than one invoice number. The payment document number must be listed for each applicable invoice number.
Plan	Retirement System Plan 1 or Plan 2.
Reporting Period or Invoice Number	Enter the invoice number to which you wish to apply the payment. For transmittals, the invoice number is the transmittal reporting period month and year (051998 for May 1998). For invoices, use the unique 8-digit Invoice Number that appears on the invoice.
Amount	Enter the amount being paid against each invoice.
Plan Total and System Total	Enter the plan total and system total on each page. If you use more than one page for a single invoice or payment item number, please total each page separately.

Mailing the Form

Mail this form to the address shown on the front page of this form.

Note: Use this post office box for payments and payment forms only!

State of Washington

Department of Retirement Systems

Plan 3 Change of Investment Program

Use to change the investment program to which your contributions are sent

Department of Retirement Systems
PO Box 48380
Olympia, WA 98504-8380
Toll Free: 1-800-547-6657
Local: 360-664-7000
TDD: 360-586-5450

Return completed form to your employer

Section 1: Personal Data - To Be Completed by Member

Social Security Number

☐ SERS ☐ TRS

Check your Retirement System

Last Name

First Name

Middle Name

Maiden Name

Section 2: Change of Investment Program - To Be Completed by Member

To obtain more detailed information about an investment program consult the *Plan 3 Investment Guide*. Investment guides are available from your employer or through ICMA-RC (1-888-711-8773).

Place a check mark in the box next to the investment program you choose.

- ❑ Direct my future contributions to the **Washington State Investment Board (WSIB) Investment Program.**
- ❑ Direct my future contributions to the **Self-Directed Investment Program.** You can select the allocation of your contributions by contacting ICMA Retirement Corporation (ICMA-RC) at 1-888-711-8773 or by accessing their Web site (http://www.icmarc.org/plan3).

Any contributions made prior to this change and the earnings generated by those funds will remain in the current investment program unless you request that they be transferred. To transfer fund balances between investment programs contact ICMA-RC toll-free at 1-888-711-8773 from 5:30 a.m. to 6:00 p.m. Pacific Time, Monday through Friday (on business days).

Employee Signature

M	M	D	D	Y	Y	Y	Y

Date

26 U.S.C. Sections 6047(D), 6041(A), and 6109(A)(3) authorize DRS to solicit your Social Security Number.

- DRS uses your Social Security Number to ensure that any amounts disbursed under your account are properly reported to the Internal Revenue Service and as a reference number for tracking all data with regard to your retirement account.
- Routinely, DRS uses the Social Security Number as the identifying number for the member file.
- If you do not provide your Social Security Number, DRS cannot guarantee that the information you are providing on this form will be properly matched with your member records. This is a particular risk if your name is a fairly common one. Failure to provide your Social Security number may also result in misreporting to the Internal Revenue Service any disbursements you receive, which may result in adverse tax consequences for you.
- Because this form affects how DRS reports your disbursements to the IRS, the disclosure of your Social Security Number to DRS is mandatory.
- DRS will not disclose your Social Security Number to any party unless required by law.

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State of Washington

Department of Retirement Systems

Plan 3 Member Information

For selecting an investment program and contribution rate, and for transferring from Plan 2 to Plan 3

Department of Retirement Systems
PO Box 48380
Olympia, WA 98504-8380
Toll Free: 1-800-547-6657
Local: 360-664-7000
TDD: 360-586-5450

Return completed form to your employer

INSTRUCTIONS: *This is a two-sided form, be sure it is completed as noted below* and return to your employer.

- If you are enrolling in Plan 3 for the first time or, if you are returning to Plan 3 employment with a new employer, complete Sections 1, 2, and 3.
- If you are transferring from Plan 2 to Plan 3, complete Sections 1, 2, 3, and 4. Your employer completes Section 5.
- To obtain more detailed information about the two available investment programs consult the *Plan 3 Investment Guide*. Investment guides are available from your employer or through ICMA-RC by calling 1-888-711-8773.

Section 1: Personal Data - To Be Completed by Member

Social Security Number (See back of form)

☐ SERS ☐ TRS

Check your Retirement System

Last Name

First Name

Middle Name

Maiden Name

Section 2: Selection of Contribution Rate - To Be Completed by Member

- New members and members who change employers have 90 days to choose a contribution rate option. If a rate option is not chosen within 90 days of your eligibility date, your employer must report Option A.
- Plan 2 members who transfer to Plan 3 must select a contribution rate option at the time of transfer.
- Once selected, a contribution rate cannot be changed as long as the member remains with the same employer.
- Plan 3 contributions will begin with the earliest possible pay period following completion of this form.

Place a check mark in the box next to the contribution rate option you choose:

- ❑ **Option A:** 5 percent of pay at all ages
- ❑ **Option B:** 5 percent of pay until age 35; 6 percent from age 35 until 45; 7.5 percent from age 45 and above
- ❑ **Option C:** 6 percent of pay until age 35; 7.5 percent from age 35 until 45; and 8.5 percent from age 45 and above
- ❑ **Option D:** 7 percent of pay at all ages
- ❑ **Option E:** 10 percent of pay at all ages
- ❑ **Option F:** 15 percent of pay at all ages

Employee Signature

M	M	D	D	Y	Y	Y	Y

Date

Section 3: Selection of Investment Program - To Be Completed by Member

You can obtain information about both investment programs by contacting ICMA-RC toll-free at 1-888-711-8773. If you select the Self-Directed Investment Program, set up your allocation among the fund choices online at http://www.icmarc.org/plan3 or by calling ICMA-RC at 1-888-711-8773.

Place a check mark in the box next to the investment program you choose:

- ❑ Direct my contributions to the **Washington State Investment Board (WSIB) Investment Program.**
- ❑ Direct my contributions to the **Self-Directed Investment Program**. Call 1-888-711-8773 or go online at http://www.icmarc.org/plan3 to set up your investment allocation.

Employee Signature

Continued on back

M	M	D	D	Y	Y	Y	Y

Date

Section 4: Request for Transfer to Plan 3 - To Be Completed by Member

I understand that my transfer to Plan 3 is irrevocable. I request that I be transferred from Plan 2 to Plan 3.

✍ Please sign and date this form on the day that you submit it to your employer.

M	M	D	D	Y	Y	Y	Y

Employee Signature

Date

Section 5: To Be Completed by Employer

Print or type employer name and mailing address below:

Reporting Group

Employers: Please mail the original of this document to DRS only if a Plan transfer has been requested.

26 U.S.C. Sections 6047(D), 6041(A), and 6109(A)(3) authorize DRS to solicit your Social Security Number.

- DRS uses your Social Security Number to ensure that any amounts disbursed under your account are properly reported to the Internal Revenue Service and as a reference number for tracking all data with regard to your retirement account.
- Routinely, DRS uses the Social Security Number as the identifying number for the member file.
- If you do not provide your Social Security Number, DRS cannot guarantee that the information you are providing on this form will be properly matched with your member records. This is a particular risk if your name is a fairly common one. Failure to provide your Social Security number may also result in misreporting to the Internal Revenue Service any disbursements you receive, which may result in adverse tax consequences for you.
- Because this form affects how DRS reports your disbursements to the IRS, the disclosure of your Social Security Number to DRS is mandatory.
- DRS will not disclose your Social Security Number to any party unless required by law.

State of Washington
Department of Retirement Systems

PLAN 3 PAYMENT ADVICE

Employer Name:	
Reporting Group:	

Plan 3 Defined Benefit Contributions (Employer)		
Payment Number	**Reporting Period or Invoice Number**	**Amount**

Defined Benefit Total for This Page $

Plan 3 Defined Contributions (Member)			
Payment Number	**Reporting Period or Invoice Number**	**Amount**	**Investment Program**

Defined Contribution Total for This Page $

Plan 3 Total for This Page $

Mail this form *with the payment* to:	**For DRS use only**
Department of Retirement Systems **PO Box 9018** **Olympia WA 98507-9018**	**DRS Receipt Number:**

DRS MS 137 (R5/00)

Using the Plan 3 Payment Advice Form

General Information

Use this form to report payments **for Plan 3 only**. Use a separate form for each reporting group.
(Use DRS MS 136, revised 5/00, for Plan 1 and Plan 2.)

To redistribute a previous payment, use the Credit Redistribution form.
(DRS MS 137, revised 5/00.)

Electronic fund transfers transmitted through the Washington State Department of Personnel's Human Resource Information Systems Division (HRISD) and the Center for Information Services (CIS) are not reported on this form.

If you have any questions about completing this form, please call your account manager listed on your statement.

Completing the Form

Employer Name	Enter your organization's name as shown on your Statement of Account Activity.
Reporting Group	Enter your DRS Reporting Group as shown on your Statement of Account Activity, e.g., 311003. If you have payments for more than one Reporting Group, use a separate form for each.
Payment Number	Enter the number of the check, warrant, journal voucher (JV) or other payment document. A single payment document may be used for more than one invoice number. The payment document number must be listed for each applicable invoice number.
Reporting Period or Invoice Number	Enter the invoice number to which you wish to apply the payment. For transmittals, the invoice number is the transmittal reporting period month and year (052000 for May 2000). For invoices, use the unique 8-digit Invoice Number that appears on the invoice.
Defined Benefit Total	Enter the total paid for the defined benefit portion of your payment reported on this page. These are the employer contributions.
Amount	Enter the amount you want applied to the invoice. For Defined Contribution payments, use the abbreviation for the appropriate Investment Program. Use "W" for Washington State Investment Board or "S" if the funds are for the Self-Directed Investment Program.
Defined Contribution Total	Enter the total paid for the defined contribution portion of your payment reported on this page. These are the member contributions.
Plan 3 Total	Enter the grand total for the Defined Benefit and the Defined Contribution payments. If you use more than one page for a single invoice or payment number, please total each page separately.

Mailing the Form

Mail this form to the address shown on the front page of this form.

Note: Use this post office box for payments and payment forms only!

Position Eligibility Worksheet∗

Employee Name:______________________________SSN:__________________

Current Position

Eligibility evaluated ____/____/___ Date employee entered position____/____/____

Position title____

Position number (if applicable)____

Is this a new or an existing position? New ❑ Existing ❑

If existing, position formerly held by: ____

1. Does this position ever require work for at least 70 hours per month?

   Yes ❑ No ❑ If yes—go to next question
   If no—position not eligible at this time.

2. Does this position require work for at least 5 months of at least 70 hours each month during a 12-month period?

   Yes ❑ No ❑ If yes—go to next question
   If no—position not eligible at this time.

3. Is the position established on an ongoing basis (not a project position with an expected termination date)?

   Yes ❑ No ❑ If yes—position appears to be eligible
   If no—position may not be eligible

4. Does the employee work in more than one position for you?

   Yes ❑ No ❑ If yes, explain: ____

5. Do other employees work in this position?

   Yes ❑ No ❑ If yes, explain:, ____

6. Is the position considered eligible?

   Yes ❑ No ❑

If position is ineligible, give the reason for your determination. ________________________________

∗ This worksheet is for PERS Plan 1 and Plan 2; SERS Plan 2 and Plan 3; and TRS Plan 2 and Plan 3.

Employee’s Understanding of Position Eligibility

Check the appropriate boxes below:

I understand this position is:

❑ eligible ❑ ineligible

For membership in the Public Employees’ Retirement System (PERS)

❑ Plan 1 ❑ Plan 2

For membership in the School Employees’ Retirement System (PERS)

❑ Plan 2 ❑ Plan 3

For membership in the Teachers’ Retirement System (TRS)

❑ Plan 2 ❑ Plan 3

______________________________ ______________________________
Employee’s Signature Date

Eligibility Review

Employers should review eligibility determinations periodically.

Reviewer ______________________ Date Reviewed ______________
Eligibility has changed Yes❑ No ❑ Comment ______________

Reviewer Date Reviewed

Eligibility has changed Yes ❑ No ❑ Comment

Reviewer Date Reviewed
Eligibility has changed Yes ❑ No ❑ Comment

Reviewer Date Reviewed
Eligibility has changed Yes ❑ No ❑ Comment

Reviewer Date Reviewed
Eligibility has changed Yes ❑ No ❑ Comment

Washington State Department of Retirement Systems **Prelist Supplement Form**

Rpt Type	Rptg Group (Dept)	System	Plan	Report Period	Employer Name	Page
R						

Member Information	Earnings Information Earning Period	Status	Compensation	Member Contributions	Employer Contributions	Hours/ Days	Begin Date	End Date
SSN: Name: Gender: Birth: Type:								
SSN: Name: Gender: Birth: Type:								
SSN: Name: Gender: Birth: Type:								
SSN: Name: Gender: Birth: Type:								
SSN: Name: Gender: Birth: Type:								
SSN: Name: Gender: Birth: Type:								
SSN: Name: Gender: Birth: Type:								
SSN: Name: Gender: Birth: Type:								
SSN: Name: Gender: Birth: Type:								
SSN: Name: Gender: Birth: Type:								
SSN: Name: Gender: Birth: Type:								
SSN: Name: Gender: Birth: Type:								
	Page Total							
	Plan Total							
	System Total							

1. Insert this form into the prelist where you need extra pages.
2. Change preprinted page numbers on the prelist as needed.
3. Enter page, plan and system totals on this page as needed.

Blank page

WASHINGTON STATE TEACHERS' RETIREMENT SYSTEM (TRS)
P.O. Box 48380, Olympia, Washington 98504-8380 (360) 709-4700

PROOF OF EARNABLE COMPENSATION

EMPLOYEE'S NAME: ____________________ EMPLOYER'S NAME: _______________

EMPLOYEE'S SS#: ____________________ EMPLOYER'S ADDRESS: _______________

TRS RETIREMENT DATE: ________________ _______________

The following information must be completed in order to finalize this account. Please keep in mind the totals listed below must match what has been reported on the transmittal system. If the amounts do not match, please explain why.

Transmittal Total:	July 1, 19__ through June 30, 19__	$	________________
Contract Total:	July 1, 19__ through June 30, 19__	$	________________
	July 1, 19__ through June 30, 19__	$	________________
	July 1, 19__ through June 30, 19__	$	________________
	Total Earnable Compensation	$	________________
Transmittal Total:	July 1, 19__ through June 30, 19__	$	________________
Contract Total;	July 1, 19__ through June 30, 19__	$	________________
	July 1, 19__ through June 30, 19__	$	________________
	July 1, 19__ through June 30, 19__	$	________________
	Total Earnable Compensation	$	________________

Employee's last day of work: ____________

VACATION LEAVE CASHOUT

Beginning balance of vacation days as of June 30, 19__ ________________

Earned 1st year: 19__/19__ ________________
Taken 1st year: 19__/19__ ________________

Earned 2nd year: 19__/19__ ________________
Taken 2nd year: 19__/19__ ________________

Net vacation leave at retirement for compensations: ________________

____Days accrued leave @ $____________
Date paid:______________ Total paid: $ ________________

I do hereby certify the above information is a true and correct record of the total earnable compensation paid to the above-named employee for the period indicated.

____ ____
Signature of Certifying Officer Telephone Number

____ ____
Title of Certifying Officer Date Completed

COPIES OF ALL CONTRACTS AND VACATION LEAVE AGREEMENTS MUST BE ATTACHED

Blank page

Washington State Department of Retirement Systems

Retiree Returning to Work Report

System	Employer Name	Prepared By	Date	Phone	Page

Retiree Information		Employment Information									
		Begin Date			End Date						
		MM	DD	YYYY	MM	DD	YYYY	Position Status			
SSN:	Name:							Eligible:		Ineligible	
SSN:	Name:							Eligible:		Ineligible	
SSN:	Name:							Eligible:		Ineligible	
SSN:	Name:							Eligible:		Ineligible	
SSN:	Name:							Eligible:		Ineligible	
SSN:	Name:							Eligible:		Ineligible	
SSN:	Name:							Eligible:		Ineligible	
SSN:	Name:							Eligible:		Ineligible	
SSN:	Name:							Eligible:		Ineligible	
SSN:	Name:							Eligible:		Ineligible	
SSN:	Name:							Eligible:		Ineligible	
SSN:	Name:							Eligible:		Ineligible	
SSN:	Name:							Eligible:		Ineligible	
SSN:	Name:							Eligible:		Ineligible	
SSN:	Name:							Eligible:		Ineligible	
SSN:	Name:							Eligible:		Ineligible	
SSN:	Name:							Eligible:		Ineligible	
SSN:	Name:							Eligible:		Ineligible	
SSN:	Name:							Eligible:		Ineligible	
SSN:	Name:							Eligible:		Ineligible	

Mail Completed form to:
Employer Support Services
Department of Retirement Systems
P.O. Box 48380
Olympia, WA 98504-8380

DRS MS 138 (R5/00)

USING THE RETIREE RETURNING TO WORK REPORT

To complete this form:

Use this form when you hire a retiree and send the begin date. When the retiree's employment has ended, send the termination date.

1. Fill in the employer and system information requested at the top of this form:

   The retirement system the retiree who is returning to work is **working in** (only one system per page)
   - *L* = Law Enforcement Officers' & Firefighters Retirement System
   - *P* = Public Employees' Retirement System
   - *E* = School Employees' Retirement System
   - *S* = State Patrol
   - *T* = Teachers' Retirement System

   The employer's name
   The name of the person preparing the form
   The date the form was mailed to DRS
   The telephone number of the person who completed the form
   Page number

2. Complete the retiree information for the transactions you are submitting:

   Enter the retiree's Social Security number
   Enter the retiree's Name

3. Complete the employment information for the transactions you are submitting:

   Enter the retiree's date of hire in their current position in the begin date columns (mmddyyyy)
   Enter the retiree's termination of employment date in the end date columns (mmddyyyy) - DRS cannot accept end dates beyond the current date
   Put an "X" in the box to the right of the position status that applies to each retiree

4. Make a copy of the form for your records.

5. Send the form to DRS at the address given in the lower right corner of this form.

Note: Regarding use of the date fields:

The appropriate dates and other applicable information should be submitted if a retiree moves from an eligible position to an ineligible position or vice versa.
This information determines when a retiree's monthly benefit will be suspended or when it can resume.

Note: Regarding position status:

Use the PERS/SERS definition for position eligibility when you are reporting retirees in PERS/SERS positions.
Use the TRS Plan 2 definition for position eligibility when you are reporting retirees in TRS positions (including TRS Plan 1 retirees).
Use the full-time, fully compensated LEOFF definition for position eligibility when you are reporting retirees in LEOFF positions. (If a retiree of LEOFF is hired into a position that is eligible for LEOFF, the retiree should be reported on the Monthly Contribution Transmittal Report and not the Retirees Who Return to Work Report.
Use the Washington State Patrol Retirement System (WSPRS) definition for position eligibility when you are reporting retirees in WSPRS positions.

Refer to DRS Notice 97-002 for more information or call Employer Support Services at (360) 664-7200 or 1-800-547-6657 ext. 47200 if you have any questions.

Retirement Status Form*

Employee Name________________________________**SSN**____________________

Retirement Status

Have you ever been a member of a Washington State Retirement System? Yes ❑ No ❑

If yes, what system and plan?

Teachers' Retirement System	Plan 1 ❑ Plan 2 ❑ Plan 3 ❑
Public Employees' Retirement System	Plan 1 ❑ Plan 2 ❑
School Employees' Retirement System	Plan 2 ❑ Plan 3 ❑
Law Enforcement Officers' and Fire Fighters' Retirement System	Plan 1 ❑ Plan 2❑
Washington State Patrol Retirement System	❑
Judicial Retirement System	❑
Do not know	❑

Other____

Have you withdrawn your retirement contributions? Yes ❑ No ❑ N/A ❑ Do not know ❑

Have you ever **retired** from one of the above Washington State Retirement Systems?
Yes ❑ No ❑

____ ____________________
Employee Signature Date

Completed form to be filed in employee's file.

* RCW 41.50.139 requires employers to solicit this information from all new employees.

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Washington State Department of Retirement Systems

TRS Plan 1 Retiree Returning to Work Report

System/Plan	Employer Name	Prepared By	Date	Phone	Page
TRS 1					

Retiree Information		Employment Information Begin Date - MM/DD/YYYY			End Date - MM/DD/YYYY			Position Status			
SSN:	Name:							On-Call:		Contracted:	
SSN:	Name:							On-Call:		Contracted:	
SSN:	Name:							On-Call:		Contracted:	
SSN:	Name:							On-Call:		Contracted:	
SSN:	Name:							On-Call:		Contracted:	
SSN:	Name:							On-Call:		Contracted:	
SSN:	Name:							On-Call:		Contracted:	
SSN:	Name:							On-Call:		Contracted:	
SSN:	Name:							On-Call:		Contracted:	
SSN:	Name:							On-Call:		Contracted:	
SSN:	Name:							On-Call:		Contracted:	
SSN:	Name:							On-Call:		Contracted:	
SSN:	Name:							On-Call:		Contracted:	
SSN:	Name:							On-Call:		Contracted:	
SSN:	Name:							On-Call:		Contracted:	
SSN:	Name:							On-Call:		Contracted:	
SSN:	Name:							On-Call:		Contracted:	
SSN:	Name:							On-Call:		Contracted:	
SSN:	Name:							On-Call:		Contracted:	
SSN:	Name:							On-Call:		Contracted:	
SSN:	Name:							On-Call:		Contracted:	

Mail Completed form to:

Employer Support Services
Department of Retirement Systems
P.O. Box 48380
Olympia, WA. 98504-8380

USING THE TRS PLAN 1 RETIREE RETURNING TO WORK REPORT

To complete this form:

1. Provide all the information requested at the top of this form:
   - The employer's name
   - The name of the person preparing the form
   - The date the form was mailed to DRS
   - The telephone number of the person who completed the form
   - Page number
2. Complete the retiree information for each of the transactions you are submitting:
   - Enter the retiree's Social Security Number
   - Enter the retiree's Name
3. Complete the employment information for each of the transactions you are submitting:
   - Enter the retiree's date of hire in the current position in the begin date columns (mmddyyyy)
   - Enter the retiree's termination of employment date in the end date columns (mmddyyyy)
     - DRS can not accept end dates beyond the current month
     —End dates must be submitted on a second report unless the employment period is in only one month.
   - Put an "X" in the box to the right of the position status that applies to each retiree
4. Make a copy of the form for your records.
5. Send the form to DRS at the address given in the lower right corner of this form.

Note: Regarding use of the date fields:

- The appropriate dates and other applicable information should be submitted if a retiree moves from an On-Call position to a Contracted position or vice versa.
- This information determines when a retiree's monthly benefit will be suspended or when it can resume.

Note: Regarding position status:

- Contracted versus On-Call has a direct impact on how many hours a TRS Plan 1 retiree can work during the fiscal year (July – June). It is critical to keep DRS informed of the employee's position status. If you have an employee who is performing both On-Call and Contracted work, you must put an "X" in the box to the right of the Contracted box.

Refer to DRS Notice 99-006 for more information or call Employer Support Services at (360) 664-7200 if you have any questions.